REPRODUCTIVE HEALTH matters

FEATURE

Advancing adolescent capacity to consent to transgender-related health care in Colombia and the USA

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Abstract: *Many sexual and reproductive health care services, including gender reassignment treatment, facilitate reproductive autonomy and self-determination of gender identity. Individuals who are unable to refuse or consent to these services on their own behalf, such as adolescents, are at risk of violations of their rights to privacy and self-determination. This paper explores the issue of adolescent capacity to consent to transgender-related health care in Colombia and the United States (USA), focusing on the two countries' struggles to balance the rights of adolescents to make autonomous and confidential decisions with the rights of their parents. Unfortunately, many countries, including Colombia and the USA, have been slow to develop jurisprudence and legislation that explicitly protect transgender adolescents' capacity to consent to gender assignment treatment. Courts in Colombia, however, have developed jurisprudence that restricts parents' ability to make medical decisions on behalf of their infant intersex children, which lays a strong normative foundation for advancing adolescent capacity to consent to transgender-related health care. It is a strategy that may prove effective in other countries in the Americas, even those with different frameworks for adolescent medical decision-making capacity, such as the USA.*

Keywords: adolescents and young people, law and policy, sexual rights, intersex issues, transgender issues, agency and decision-making capacity, Colombia, USA

According to international human rights norms, adolescents* are entitled to confidential and comprehensive sexual and reproductive health services.[3] Countries, however, face obstacles that interfere with their ability to adequately meet these obligations. For example, legislatures and courts in the USA have frequently struggled to balance the rights of adolescents to make autonomous and confidential decisions pertaining to their sexual and reproductive health, with the rights of their parents.[4] Accordingly, domestic legislation often reflects the traditional presumption that adolescents do not have the capacity to make autonomous decisions and transfers decision-making authority to parents or legal representatives, as appropriate. As a result, adolescents generally cannot access or consent to many sexual and reproductive health services without parental involvement.

Many sexual and reproductive health care services facilitate reproductive autonomy and self-determination of gender identity. The decision to undergo (or not undergo) gender reassignment treatment, for example, has lifelong consequences for the individual who undergoes (or does not undergo) the treatment. As a result, individuals who are unable to refuse or consent to these services on their own behalf, such as adolescents, are at risk of violations of their rights to privacy and self-determination. In some parts of the world, particularly in Europe, courts and legislatures have extended the right to access transgender-related health care services

*An adolescent is a person between the ages of 10 and 19 years.[1] A child is a person below the age of 18 years, unless under the law applicable to the child, majority is attained earlier.[2] A minor is a person who has not yet reached the legal age of majority. While this paper focuses on adolescent capacity, many of the laws and the jurisprudence discussed here address all minors and do not distinguish between adolescents and younger children. Where appropriate, the term "minors" will be used instead of "adolescents".

 Doi: 10.1016/S0968-8080(13)41695-6

to adolescents.[5,6] Countries in the Americas, like the USA and Colombia, have been slower to develop jurisprudence and legislation that explicitly protect transgender adolescents' capacity to consent to gender assignment treatment. Courts in Colombia, however, have developed jurisprudence that restricts parents' ability to make medical decisions on behalf of their infant intersex children, which lays a strong normative foundation for advancing adolescent capacity to consent to transgender-related health care. It is a strategy that may prove effective in other countries in the region, even those with different frameworks for adolescent medical decision-making capacity, such as the USA.

This paper explores the obstacles to and opportunities for advancing adolescent capacity to consent to transgender-related health care in Colombia and the USA, the authors' countries of expertise. It contrasts the two countries' struggles to balance the rights of adolescents to make autonomous and confidential decisions pertaining to their health, with the rights of their parents. It then considers the utility of some alternative legal doctrines available under Colombian and USA law, in the absence of explicit jurisprudence and legislation protecting adolescents' right to consent to transgender-related health care services. Lastly, it explores the role that jurisprudence restricting parental authority to consent to genital surgery on their intersex infants has played in Colombia – and has the potential to play in the USA – in advancing adolescent capacity to consent to transgender-related health care.

Adolescent capacity in medical decision-making

The Hastings Center, a non-partisan non-profit bioethics research institute, defines decision-making capacity as existing when a patient has the ability to (a) comprehend information relevant to the decision, (b) deliberate about choices in accordance with personal values and goals and (c) communicate verbally or nonverbally with caregivers.[7] Decision-making capacity also requires the ability to provide consent that goes beyond merely acquiescing or deferring to authority. Accordingly, a health care provider should ultimately base an evaluation of an adolescent's decision-making capacity upon his or her *"ability to understand and communicate relevant information, ability to think and choose with some degree of independence, ability to assess the potential for benefit, risks, or harms, as well as to consider the consequences and multiple options"*.[8]

Health care providers' experience with young patients in some countries, including the USA, has shown that adolescents possess a decision-making capacity on a par with that of young adults.[8] According to Prof Kimberly Mutcherson, in one study, American health care providers reported that adolescent patients *"understand information about medical treatment and conditions, engage in rational deliberation during the decisional process, and communicate choices and concerns clearly"*.[8,9] They also perceived their adolescent patients as possessing communication skills that allowed them to successfully discuss and share their health care preferences, preferences which they perceived as products of rational thought.[8] Despite the growing scientific and developmental research discrediting the presumption of adolescent decisional incapacity,[8,10] domestic laws continue to limit adolescents' ability to consent to many types of health care.

Legislatures and courts in the USA, as well as Colombia, have struggled to balance the rights of adolescents to make autonomous and confidential decisions pertaining to their sexual and reproductive health, with the rights of their parents. As is the case in many societies, age is the key determinant in the acquisition of formal rights, marking the threshold at which adolescents achieve greater autonomy over their own lives. Unfortunately, the rigid application of laws that prescribe ages at which rights come into play does not always reflect the reality of adolescents' capacity to make decisions.[9]

Colombia

Colombian law presumes that individuals under the age of 18 generally do not have the capacity to provide legal consent to health services.[11] Accordingly, the Colombian Constitution, the Civil Code and the Code of Infancy and Adolescence recognize various parental rights and responsibilities. Article 288 of the Civil Code, for example, recognizes and protects parents' *patria potestad* (parental authority) over their children.[12] However, Colombian law explicitly recognizes and protects the basic rights of children under Article 44 of the Constitution, which protects their rights to *"[l]ife, physical integrity, health and social security, a balanced diet, their name and citizenship, to*

have a family and not be separated from it, care and love, instruction and culture, recreation, and the free expression of their opinions".[13] Parental responsibility, as a result, encompasses the obligation to orient, care for, accompany and raise their children during their formative years and to ensure *"the maximum realization of their children's rights"*. According to Article 14 of the Code of Infancy and Adolescence, the exercise of parental responsibility should never involve physical or psychological violence or interference with children's rights. Commentators explain that Article 14 obligates parents to respect their children's autonomy and prohibits parents from imposing their *patria potestad* on their children.[11]

The Colombian Constitutional Court has held that a child's autonomy places limits on his or her parents' ability to make medical decisions on behalf of that child. In Decision T-474 of 1996,* the Court held that human development is a process and, as a result, human beings do not acquire full autonomy, or the corresponding rights and obligations, automatically. Minors' legal incapacity is therefore relative, rather than absolute.† Consequently, the Court has developed three categories of legal capacity for minors, progressively recognizing more capacity and autonomy for each group: infants, pre-pubescent children and minor adults. The Court determined that only "infants", i.e. children from birth to seven years old, have complete incapacity. "Pre-pubescent children" i.e. aged 7 to 14 years old, begin to develop the capacity to make decisions and evaluate the consequences of their actions. "Minor adults", i.e. children aged 14 to 18 years old, are afforded "relative capacity", as they have developed additional adult capacities, including moral principles and the ability to understand certain responsibilities.[14]

Accordingly, while parents have an obligation to protect the interests of their minor children, the Colombia Constitutional Court had also held that there are limits to parents' right to make decisions on behalf of their minor children in a medical context. In Decision T-477 of 1995, the Court explained that even though parents may make certain decisions regarding medical care on behalf of their children, including some that may be against the wishes of the child, this does not mean that parents can make any medical decision on behalf of their child. According to the Court, a child is not the property of his or her parents, and the child is in the process of developing liberty and autonomy and therefore receives constitutional protection. Parents and their children, as a result, have a "shared capacity" to consent in the medical decision-making context.[15]

USA

In the USA, a presumption of decisional incapacity also governs legal treatment of adolescent autonomy for many activities, including medical decision-making.[8,16] The USA Supreme Court, moreover, has held society to a "high duty" to ensure that adolescents develop into meaningful participants in their own lives.[17] Traditionally, that responsibility has fallen to parents, an assignment rooted in the dominant vision of the family as an integrated and harmonious whole, in which children do not exist apart from their parents and within which the state has very limited ability to interfere.[18] A parent's broad constitutional right to the care and custody of a child includes making decisions for minor children on a wide range of issues, including where they will live, what school they will attend and what health care they will receive.[8] Parents control and provide care for their children and, as a result, children obey parental direction because they depend on adults for privilege and access to resources.[8] There is a presumption, moreover, that *"natural bonds of affection lead parents to act in the best interests of their children"*.[18,19]

The USA Supreme Court, however, has observed that *"parents cannot always have absolute and unreviewable discretion"* to make decisions on behalf of their children.[20] In the context of medical decision-making, states have created a number of exceptions to the presumption of incapacity that allow minors to consent to their own health care.[19] These exceptions can generally be divided into two categories: (1) minors with specific

*In this case, the father of a 16-year-old Jehovah's witness requested that the Colombia Constitutional Court order a clinic to perform a blood transfusion on his son, despite the fact that the young man refused to consent to the procedure. Without the blood transfusion, which was a necessary part of the young man's cancer treatment, it was likely that he would die.[14]

† *"Minors may freely and autonomously testify, recognize children born out of wedlock and receive support, give their children up for adoption, enter into certain contracts. However, they still need parental authorization for other activities, including marriage, being adopted and entering into an employment contract."*[14]

medical conditions and (2) minors with certain legal statuses. First, minors with certain medical conditions may consent to health care relating to those conditions.[21] While the health care services covered vary by state, most states allow minors to consent to services related to sexually transmitted infections (STIs), pregnancy and mental health conditions, independent of a parent's consent or knowledge.[21,22] Second, minors who bear certain legal statuses may consent to their own health care, including emancipated minors, minors living away from home and responsibly managing their own finances, and teens who are married, pregnant or parents.[21]

A few states have also passed "mature minor" statutes. These statutes allow unaccompanied adolescents who reside at home *"to consent to and receive health services upon a medical provider's assessment that the young person demonstrates the appropriate level of emotional and cognitive development to contemplate the risks and benefits of the medical procedure"*.[21] Mature minor statutes, however, generally lack a gauge for determining "maturity", engraft a lower age limitation (usually 14 or 15) and limit adolescent decisional autonomy to consent to, rather than refuse, treatment. Other states have adopted the mature minor rule for specific situations through common law.[10]

Adolescent capacity to consent to gender reassignment treatment

Adolescents are entitled to comprehensive health services that not only advance their sexual and reproductive autonomy, but also facilitate their self-determination of gender identity. Transgender is an umbrella term for a wide range of people whose gender expression, gender identity, or both, differ from the gender they were assigned at birth.[23] The term may include, but is not limited to, transsexual and transgender people, transvestites, travesti, cross dressers, no gender and genderqueer people.[24] Gender identities, roles and expressions are diverse, and hormones and surgery are just two of many options (e.g. primary care, gynaecological and urological care, reproductive options, voice and communication therapy and mental health services) available to assist people with achieving comfort with their gendered selves. The number and type of interventions applied and the order in which these take place may differ from person to person.[25] Regardless of the medical treatment option(s) they choose, transgender adolescents are entitled to comprehensive health services that not only advance their sexual and reproductive autonomy, but also facilitate their self-determination of gender identity.*

Colombia

Neither the courts nor the legislature in Colombia regulate adolescents' capacity to consent to gender reassignment treatment. In fact, Colombian law does not explicitly provide for a general right to access transgender-related health care. The city of Bogota, however, adopted Decree No. 608 in 2007, which recognizes and respects the right of all people to construct for themselves a self-definition of their body, their sex, their gender and their sexual orientation.[27]

The Colombian Constitution and the Constitutional Court's jurisprudence, moreover, provide a strong normative foundation for protecting both transgender adults' and adolescents' right to access and consent to such treatment. Since 1988, Colombian law has permitted an individual to request an official change of his or her name on identity documents under Article 16 of the Constitution, which protects the right to the free development of the personality.[28] Arguably, Article 16's protection of free development of the personality also extends to an individual's right to undergo gender reassignment treatment. The strongest jurisprudential foundation for advancing adolescent capacity to consent to transgender-related health care, however, can be found in the Colombian Constitutional Court's decision to restrict parental authority to consent to genital surgeries performed on intersex infants (discussed further below).

USA

The general presumption of decisional incapacity currently governs adolescents' ability to consent to gender reassignment treatment and other transgender-related health care in the USA In other words, if a parent or guardian refuses to give consent to such care, transgender adolescents are prevented from medically transitioning to the

*In countries where the prescription of puberty-delaying hormones to pre-adolescent transgender children has been introduced, namely the Netherlands, USA and Australia, the practice remains controversial.[26]

gender with which they identify until they reach 18, the legal age of majority. While the advocates of transgender adolescents argue that legislatures should *"explicitly codify the right of transgender adolescents to consent to their own medical care"*, they have identified alternative legal strategies which aim to ensure that adolescents can consent to and access transgender-related health care.[29]

First, a transgender adolescent might seek emancipation from his or her parents. As discussed above, many states allow adolescents who bear certain legal statuses to consent to their own health care, including those who are married, parents or emancipated.[29] More than 30 states have codified the emancipation exception in some form. While emancipation statutes vary, most provide a number of factors that must be considered in determining whether a minor should be considered emancipated for purposes of consenting to health care.[29] In New York, for example, the Public Health Law's emancipation exception and related case law provide that minors are emancipated and competent to consent to their medical care if *"they support themselves, have been inducted into military service, have been abandoned by their parents, have constructively abandoned their parents, or have assumed a status 'inconsistent with subjection to control by his parent'"*.[29] Unfortunately, the emancipation doctrine provides adolescents with an incentive to leave their parental home, perhaps prematurely. It also terminates the emancipated adolescent's right to continued financial and other support from his or her parents.[29]

Second, a transgender adolescent might prove that he or she has the capacity to consent to gender reassignment treatment under the mature minor rule. The mature minor rule remains in effect through common law in some states and has been codified in legislation in others.[29] The common law doctrine of mature minors was established in *Cardwell v. Bechtol*, in which the Court noted that *"recognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century."*[22,30]* Rather than rely on a general presumption based upon a specific event, such as reaching a particular age, marrying or parenting a child, the mature minor rule relies on the adolescent's ability *"to appreciate his own conduct and the consequences of the conduct of others"*.[22,30] Moreover, unlike emancipation, the mature minor doctrine provides adolescents with the autonomy to make their own medical decisions while preserving the family unit.[29]

Finally, a transgender adolescent may argue that the judicial bypass provision,† established in the abortion context, is applicable to adolescents seeking other types of health care, including gender reassignment treatment. Transgender adolescents who do not wish to obtain consent from their parents for gender reassignment treatment are likely to be motivated by similar reasons as pregnant adolescents who do not wish to obtain consent from their parents for an abortion. *"If a transgender minor is forced to seek consent from a parent, the parent might take extraordinary measures to prevent the minor from accessing sex reassignment, even when the sex reassignment decision might be in the best interests of the minor… Additionally, as in the abortion context, requiring parental consent forces the minor to disclose at an inflexible time rather than letting disclosure unfold in the particular ways that are appropriate to that family's dynamics."*[29]** While the judicial bypass may be a preferable or necessary option when parents or the state, acting as guardian, will not consent to the health care the transgender adolescent seeks, it is not an ideal solution.[29] Unfortunately, as in the case of abortion, judicial bypass can interpose another barrier between the adolescent and his or her desired

* *"At common law recognition of the gradually increasing capacity of minors was called the Rule of Sevens: under the age of seven, a presumption of no capacity; from seven until fourteen a rebuttable presumption of no capacity; and from fourteen to twenty-one a rebuttable presumption of capacity."*[30]

† The Supreme Court has upheld state laws requiring parental involvement in a minor's decision to have an abortion, so long as they include an "alternative", such as a judicial bypass procedure, which waives the consent or notification requirement for those adolescent young women who cannot involve their parents. *"To benefit from the judicial bypass mechanism, a young woman must appear before a judge and prove either that she is mature enough to decide whether to have an abortion or, that despite her immaturity, an abortion would be in her best interests."*[31]

** *"For example, the minor might reasonably fear that their parent might prevent them from transitioning through violence, strict surveillance such as preventing the minor from leaving the house, and even forced institutionalization."*[29]

health care, although *"judges are no more likely to be knowledgeable about the needs of transgender adolescents than are parents or the State"*.[29] A judicial bypass provision, moreover, is likely be particularly burdensome for many transgender adolescents, given the fact that their health care needs can involve a complex series of interventions.

Advancing an adolescent right to transgender-related health care

An effective strategy for advancing an adolescent right to transgender-related health care, as developed by the Colombian Constitutional Court, involves restricting parents' ability to consent to genital surgery on their intersex infants. Intersex conditions, also known as disorders of sex development, are congenital conditions in which the development of chromosomal, gonadal or anatomical sex is atypical.[32] Variations of intersex include people with external reproductive organs of one sex and internal reproductive organs of the other sex, people with genitals that are not clearly male or female and people with an atypical chromosomal pattern.[33]*

Since the 1950s, the medical standard of care for infants born with intersex conditions characterized by atypical genital appearance has been rapid sex assignment and genital surgery, in accordance with Money and his colleagues' recommended protocol.[36] A number of adults who had been treated according to this protocol challenged the necessity and success of early genital surgery in the 1990s, claiming that surgery had caused extraordinary and irrevocable harm.[34] While intersex advocates began to challenge the standard medical practices around the same time, no country or state has enacted controlling legislation regarding this issue. Colombia, moreover, remains the only jurisdiction in which the highest court has addressed the question of whether parents have the right to authorize genital surgery on their intersex child.[37]

Colombia

The Colombian Constitutional Court has limited the authority of parents to authorize genital surgery on behalf of their intersex children. In 1995, a six-month-old boy, who was female-assigned following a traumatic accident that destroyed his penis, but who never developed a female gender identity, brought suit before the Constitutional Court.[15,38] In Decision T-477/95, the Court determined that *"parents cannot give consent on a child's behalf to determine sexual identity"* because it would violate the child's right to identity, human dignity and self-determination. Following Decision T-477/95, some surgeons in Colombia were opposed to the Court's ruling and continued to recommend intersex surgery but refused to perform the surgery.[38]

In 1999, the Constitutional Court considered two cases, which resulted in Decision T-551/99 and Decision SU-337/99, in which the physicians recommended genital surgery to the parents of a two-year old child and the parents of an eight-year-old child, respectively, but refused to proceed without a court order.[39–41] In its analysis in both cases, the Court considered the competing interests involved in infant intersex surgery: the principle of autonomy and the principle of beneficence.[39,40] As the Court later explained in Decision T-1021 of 2003, these types of cases highlight the tension between *"the principle of autonomy, which privileges the decision of the minor due to her capacity to decide, and the principle of beneficence, which permits parents to make decisions on behalf of their minor children in order to protect them from acts or omissions that threaten their life and health"*.[42]

In order to address this tension in the 1999 cases, the Court ordered the legal and medical communities to establish a new category of consent, *"qualified, persistent informed consent,"* to force parental decisions to take into account only the child's interests.[39,40] According to the Court, *"parents' authority to consent to medical procedures on behalf of children who are too young to consent for themselves depends upon (1) the exigency and urgency of the procedure; (2) how invasive and risky the procedure is; and (3) the age and degree of autonomy of the child"*. The

*Managing or treating an intersex condition or sexual development disorder may involve a range of surgical procedures (e.g. to alter appearance, allow voiding of urine, allow standing urination, allow for future menstrual flow, allow for future sexual intercourse, or support gender identity development) and non-surgical interventions (e.g. sex-hormone therapy or psychological counselling), depending on the specific condition diagnosed.[34,35] Optimal care for children with these disorders, as a result, requires an experienced multidisciplinary team comprised of a range of paediatric sub-specialists (e.g. endocrinology, urology/surgery, psychology/psychiatry, gynaecology, social work, nursing and bioethics).[35]

Court, moreover, held that parents may consent to surgery only if they have been given accurate information about the risks and the existence of alternate treatment options. Furthermore, the consent must be in written form and must be given on more than one occasion, over an extended period of time, so that the parents have time to fully comprehend their child's condition and the ramifications of alternate treatment options. For children over five years old, parents cannot consent because the child has achieved an autonomy that must be respected and has already developed a gender identity, which reduces the urgency of a decision as well as any potential benefits of surgery.[39,40]

Applying this new category of consent to the two cases at issue, the Court explained that the *"consent given by the parents for genital surgery was invalid"* in both cases.[38,43] In the case of the two-year old, the decision was found to be invalid because it was not a *"qualified and persistent informed consent."*[39] The consent of the parents of the eight-year-old was also considered invalid as the child was too old for a surrogate to consent on her behalf.[40] Since 1999, the Court has reaffirmed its decision to limit parental authority to consent to gender assignment surgery on behalf of their intersex children on multiple occasions.[42,44] The new category of consent mandated by the Court provides clear parameters for parents' ability to authorize genital surgery for their intersex children once they reach five years of age. Moreover, it provides a jurisprudential foundation for balancing the rights of parents and their adolescent children in medical decision-making under other circumstances, such as the provision of transgender-related health care.

USA

USA law has traditionally afforded parents broad authority to consent to sex assignment surgery on their intersex infant children. Since the 1970s, early surgical intervention was recommended as standard procedure in the USA for intersex infants and infants who were born with ambiguous genitalia or who had suffered traumatic genital injury.[45] Until recently, the American Academy of Pediatrics has characterized a child born with ambiguous genitalia as "a social emergency" and called for early diagnosis and treatment.[46] American courts have done little to challenge the presumption of parental medical decision-making authority in cases involving intersex infants. States, moreover, have yet to pass legislation that delays the performance of genital surgeries until the child is old enough to provide consent to the surgery, or that would limit parents' traditional authority to consent to genital surgery on behalf of their intersex children.

Intersex advocates, however, are well-positioned to call for legal institutions in the USA to follow the lead of the Colombian Constitutional Court. Despite the differences between the two countries' respective constructions of adolescent medical decision-making capacity, at least one legal theory exists under USA law that supports the restriction of a parent's right to authorize genital surgery on an intersex infant. Legal scholars have argued that the performance of surgery on intersex children constitutes a "categorical conflict" between the interests of parents and children. A categorical conflict of interests calls for placing limits on a parent's authority to consent to medical decisions for the child.[19,47] Categorical conflicts include those in which (1) the decision-maker makes treatment decisions that fall outside the range of reasonableness; (2) extraordinary medical treatment is involved; or (3) the treatment decision involves a countervailing constitutional right of the patient that, when exercised, is likely to interfere with the family member's decision.[19,47] Accordingly, parents should have limited authority to consent to genital surgeries on behalf of their intersex children, as these surgeries are unreasonable and extraordinary medical interventions that have a significant impact on the constitutional interests of the child.[19]

Conclusions

International human rights norms call for the protection and promotion of adolescents' right to access confidential and comprehensive sexual and reproductive health services.[3] The Convention on the Rights of the Child* (the Convention), adopted by the UN General Assembly in 1989, requires States *"to ensure that no child is deprived of his or her right of access to… healthcare services"*, including preventive health care and family planning education and services.[2] Moreover, the Convention recognizes "the evolving capacities

*Colombia ratified the UN Convention on the Rights of the Child on January 28, 1991. The USA, however, has yet to do so.[48]

of the child" when considering the role of parents in guiding a child's exercise of her rights.[2] According to the International Planned Parenthood Federation, "the evolving capacities of the child" standard requires a balance between recognizing children as active agents in their own lives, as people and as rights-bearers with increasing autonomy, and as being entitled to protection in accordance with their vulnerability.[49] Countries that have failed to ratify the Convention, such as the USA, have participated in conferences that adopt its "evolving capacities of the child" standard in the context of addressing adolescents' sexual and reproductive health needs.[50]

Neither Colombia nor the USA has developed jurisprudence or legislation that explicitly protects transgender adolescents' capacity to consent to gender reassignment treatment. The Colombian Constitutional Court, however, has limited parental authority to consent to genital surgery on behalf of their children, creating a clear standard for balancing the rights of parents and their intersex children under these circumstances. In the process, the Colombian Court has developed a jurisprudential framework for elevating Colombian adolescents' medical decision-making authority in other contexts, such as in accessing transgender-related health care services. This approach, moreover, has the potential to challenge the long-standing presumption of adolescent decisional incapacity that exists under USA law, advancing the capacity of American transgender adolescents to make decisions about their health care.

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Résumé

Beaucoup de services de soins de santé sexuelle et génésique, y compris le traitement pour changer de sexe, facilitent l'autonomie génésique et l'autodétermination de l'identité sexuelle. Les individus incapables de refuser ou d'accepter ces services, comme les adolescents, risquent des violations de leur droit à la confidentialité et à l'autodétermination. L'article examine la question de la capacité des adolescents à donner leur consentement à des soins de santé liés à la transsexualité en Colombie et aux États-Unis d'Amérique, en se centrant sur la lutte des deux pays pour équilibrer les droits des adolescents à prendre des décisions autonomes et confidentielles avec les droits de leurs parents. Malheureusement, beaucoup de pays, notamment ces deux-là, ont tardé à définir une jurisprudence et une législation qui protègent explicitement la capacité des adolescents transsexuels à consentir au traitement de changement de sexe. Les tribunaux en Colombie ont néanmoins développé une jurisprudence qui restreint la capacité des parents à prendre des décisions médicales au nom de leur nourrisson intersexuel, ce qui constitue un solide fondement normatif pour faire progresser la capacité des adolescents à accepter des soins de santé liés à la transsexualité. C'est une stratégie qui peut se révéler efficace dans d'autres pays aux Amériques, même s'ils disposent de cadres différents pour la capacité de décision médicale des adolescents, comme les États-Unis.

Resumen

Muchos servicios de salud sexual y reproductiva, incluido el tratamiento de reasignación de sexo, facilitan la autonomía reproductiva y autodeterminación de identidad de género. Las personas que no pueden negarse o dar su consentimiento para recibir estos servicios, tales como adolescentes, corren el riesgo de sufrir violaciones de sus derechos a la privacidad y autodeterminación. En este artículo se explora el asunto de la capacidad de los adolescentes para consentir en recibir servicios de salud para personas transgénero en Colombia y Estados Unidos (EE. UU.), con un enfoque en la lucha de los dos países por sopesar los derechos de los adolescentes de tomar decisiones autónomas y confidenciales y los derechos de sus padres. Desgraciadamente, muchos países, incluidos Colombia y EE. UU., se han demorado en formular jurisprudencia y legislación que proteja explícitamente la capacidad de adolescentes transgénero para consentir en recibir tratamiento de asignación de sexo. Sin embargo, las cortes de Colombia han creado jurisprudencia que limita la capacidad de los padres para tomar decisiones médicas en nombre de sus bebés intersexuales, lo cual sienta una sólida base normativa para promover la capacidad de los adolescentes para consentir en recibir servicios de salud para personas transgénero. Es una estrategia que podría resultar eficaz en otros países en las Américas, incluso aquellos con diferentes marcos para la capacidad de toma de decisiones médicas en la adolescencia, tales como EE. UU.